

Newark Community Consolidated School  
District # 66

5-8 Grades

Ms. Demetra Turman, Superintendent  
Ms. Pamela Rowe, Principal

**PLEASE FILL OUT 1 FORM PER ATHLETE FOR THE 2020-2021 SCHOOL YEAR (5-8 Only)**

**PARENT OR GUARDIAN PERMISSION FOR SPORTS PARTICIPATION**

Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_ Soccer \_\_\_\_\_ Volleyball \_\_\_\_\_ Cross Country \_\_\_\_\_  
Cheerleading \_\_\_\_\_ Boys' Basketball \_\_\_\_\_ Girls' Basketball \_\_\_\_\_  
Boys' Volleyball \_\_\_\_\_ B/G Track \_\_\_\_\_

\_\_\_\_\_ has my permission to participate in athletics at Newark Grade  
Student's Name School/Millbrook Jr. High School

FATHER'S NAME \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

MOTHER'S NAME \_\_\_\_\_

In case of an emergency and we are unable to contact either parent, we need the names and phone numbers of one blood relative and one neighbor who would be able to locate the parents, and/or act on their behalf.

RELATIVE'S NAME \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

NEIGHBOR'S NAME \_\_\_\_\_

Please list your hospital and doctor preference:

Hospital \_\_\_\_\_ Phone # \_\_\_\_\_ Doctor \_\_\_\_\_ Phone # \_\_\_\_\_

**PLEASE READ BEFORE COMPLETING AND SIGNING**

I hereby give my permission to any qualified physician or trainer to administer emergency treatment to the above named student when the supervisor/coach feels there is such a need for emergency treatment. YES NO

The student named above is covered by my family hospitalization and medical insurance. If yes, name of company: YES NO  
\_\_\_\_\_ OR

The student named above is covered by the insurance offered by the school. (Student MUST be covered by this insurance unless covered by family insurance listed above.) YES NO

I have received and understand the district eligibility policy.

I have received and understand the district concussion policy.

SIGNATURE OF PARENT OR GUARDIAN \_\_\_\_\_